

*Citation for published version:*

Leyer, RV & Ferrero, JP 2016, 'Social policy expansion, democracy and social mobilization in Latin America: Healthcare reform in Brazil and Mexico', *Journal of Iberian and Latin American Research*, vol. 22, no. 2, pp. 117-134. <https://doi.org/10.1080/13260219.2016.1229807>

*DOI:*

[10.1080/13260219.2016.1229807](https://doi.org/10.1080/13260219.2016.1229807)

*Publication date:*

2016

*Document Version*

Peer reviewed version

[Link to publication](#)

This is an Accepted Manuscript of an article published by Taylor & Francis in *Journal of Iberian and Latin American Research* on 21 Sep 2016, available online:  
<http://www.tandfonline.com/10.1080/13260219.2016.1229807>

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## **Social Policy Expansion, Democracy and Social Mobilisation in Brazil and Mexico**

### **Introduction**

Social policy in Latin America has been transformed in recent decades. After a long period that lasted for most of the twentieth century when it was based on social insurance programmes of limited coverage, since the 1980s, coinciding with processes of democratisation, new programmes have been created to take social protection to groups of the population never reached before. This process can be observed throughout the region, however, the modes of expansion and their consequences for the welfare of the population show great variations. The Brazilian and Mexican healthcare reforms represent two exemplary cases to explore the causal processes of two different policy reform paths that have had different outcomes.

Before the reforms, healthcare in both countries was provided through social insurance programmes with coverage levels that barely surpassed half of the population (Filgueira and Filgueira, 2002). The Brazilian reform consisted on the replacement of the social insurance programme with a system that offered universal coverage as a right of citizenship—a rare case of universalism in Latin American social policy—. In Mexico, coverage was expanded by layering a targeted insurance programme along the existing social insurance programmes, reinforcing the segmentation of public healthcare provision. This article aims to explain why different reform models were chosen in each country after decades of similar paths in public healthcare provision. The main argument made here is that the difference is due to the influence that social mobilisation had on processes of democratisation and institutional and policy changes.

The article is divided in four parts. The first one presents the rationale, objectives and approach to the comparative study. The second section provides a brief narrative of the history of each healthcare system. The third section explains in comparative perspective the causal mechanisms of the reforms, discussing the ways in which democracy and social mobilisation shaped each reform and the timing and sequencing of events. The final section offers some concluding reflections.

### **Comparing healthcare in Brazil and Mexico: rationale, objectives and approach**

When it comes to social policy, different reform models will have different impact on the welfare of the population. By locking-in the middle classes, increasing the amount of resources available for redistribution and the levels of political support for redistributive policies, social programmes based on universal principles are commonly viewed as holding a stronger potential at addressing social problems. On the contrary, targeted programmes are signalled for dividing the population, discouraging the payment of taxes by non-beneficiaries, limiting public resources available to tackle social problems and diminishing levels of political support for redistribution (Korpi and Palme, 1998, Huber and Stephens, 2012, Ortiz and Cummins, 2011). Evidence from the Brazilian and Mexican healthcare systems would confirm these arguments. Public healthcare spending in Brazil has remained at higher levels than in Mexico

since the mid-1990s, with an increasing gap in recent years (CEPAL, 2013); recent quantitative research on the impact of both systems has revealed that the Brazilian universal system is more progressive and benefits low income population to a larger extent than the Mexican segmented system (Lustig et al., 2013).

Democracy has been linked to social policy expansion in Latin America under diverse mechanisms. In the cases compared in this article, both healthcare reforms were introduced immediately after each country's transitions to pluralist democratic systems. The article reviews different mechanisms by which democracy has been associated to policy changes in the region, in order to identify and test the one(s) that can explain the choices of divergent reform models in the two cases under analysis. The main objective is to explain how, in the context of recent democratisation, can a universal healthcare system that holds greater potential to improve living standards emerge, and in contrast, what are the political conditions that can lead to the reproduction of an unequal and fragmented model of welfare provision.

The article makes use of a variety of sources from different bodies of literature to build a comprehensive account of each policy reform process and their causes, including health and history journals, and published interviews with stakeholders. Sources were selected because they either explain the characteristics of each reform, the logics that were followed in their design or the political socio-political arrangements that led to their approval.

The study uses historical-institutionalism (Pierson, 2004, Hacker, 2004) and process tracing (Bennett and Checkel, 2015b, Mahoney, 2015, Collier, 2011) to make causal inferences about the reforms. Historical institutionalism offers the first approximation to the conditions that triggered and shaped each reform, but does not explain the different choices of reform models. Process tracing and an ideational perspective explain why different models were selected.

## **Healthcare Development in Brazil and Mexico**

For most of the twentieth century, in the contexts of corporatist, populists and (semi)authoritarian regimes, public healthcare provision in Brazil and Mexico was based on social insurance programmes for workers paying contributions and their families, excluding large sectors of the population. After each country's transition to pluralist competitive electoral systems, healthcare was reformed to expand coverage to the population previously excluded, but the models followed were different: Brazil substituted the social insurance programme with a universal programme that offered coverage as a right of citizenship, Mexico created an additional insurance programme targeted at poor population.

### *The Brazilian Case*

Brazil adopted its first social security legislation, based on social insurance principles, in the second decade of the twentieth century in what was known as the *Lei Eloy Chavez*, which introduced the *Caixas de Aposentadoria e Pensões* (CAPs) that tied healthcare entitlements to worker and employer's contributions, under tripartite administration with representatives from employer organisations and trade unions (Huber, 1996, Hunter and Borges Sugiyama, 2009). In the 1930s the government of Getúlio Vargas created the *Institutos de Aposentadoria*

e *Pensões* (IAPs) that replaced the CAPs, organising the system by professional associations. This reform reinforced the philosophy of social insurance in healthcare provision established a decade earlier although following a more centralised fashion, yet still highly stratified. Later, in 1945 Vargas would attempt to unify the social security system but failed due to the strong opposition of an empowered labour movement.

Until the 1960s Brazil experienced periods of varying degrees of political liberalisation and pluralist democracy until 1964, when a coup against the government of João Goulart established military rule that would last for 20 years. The military government replaced union representatives in the administration of social security with government and military employees, and unified the social insurance schemes through the creation of the *Instituto Nacional de Previdência Social* (INPS). This period was also be critical because it set the ground for the increasing presence of the private sector in the healthcare system through the form of subcontracts, i.e. the INPS provided a public service which was delivered by the private sector (Fleury, 2011).

By the late 1970s and early 1980s, pressures for greater democratisation had grown stronger, converging in a common-for-all protest movement called *Diretas Já* (Direct Elections Now!). Brazil's political democratic transition encompassed the transition from military rule with the participation of a broad range of social, cultural and political demands. The country experienced the emergence of new grass-roots social movements that shaped the mode of the political transition, like the *novo sindicalismo* (new unionism) in the industrial, urban peripheries of Sao Paulo, and the *Movimento dos Trabalhadores Rurais Sem Terra* (MST), organising landless peasants. These and other movements stemmed from the ecclesiastical base communities (CEBS), a Catholic grass-roots political movement, popular in Latin America in the 1960s and 1970s, which sought popular emancipation from below (Gohn, 2010, Caldeira, 2008).

The *Movimento pela Reforma Sanitária* (Movement for Health Reform) would be of particular importance for welfare reform. It emerged in the 1970s with the support, again, of the Catholic Church and universities, and the mobilisation in several cities of urban sectors discontent with the results of the existing healthcare system. The movement gathered progressive public health practitioners who demanded a new agenda with regards to healthcare. Social movements like the ones mentioned here positioned the narrative of the country's 'social debt' with the poor majority and the establishment of social rights in the agenda of the transition (Sader, 1999, Cornwall and Shankland, 2008).

Eventually, civil rule returned in 1985, when the candidate from the *Partido do Movimento Democrático Brasileiro* (PMDB) won the first indirect elections in which civilians were allowed to participate in more than two decades. The PMDB was a centrist umbrella party in which several groups from varied political orientation opposed to military rule coalesced, but crucial to its arrival to power was the alliance with the conservative *Partido da Frente Liberal* (PFL), formed by defectors of the official political party of the military government, named *Aliança Renovadora Nacional* (ARENA), that had joined the *Diretas Já* movement (Santos, 2003).

Members of the *Movimento pela Reforma Sanitária* gained leverage in the transition government. Notably Sérgio Arouca, one of its leaders, militant of the Communist party and researcher of the National School of Public Health, became a key advisor of the Ministry of Health. This group of health activists and academics came to be known as the *sanitaristas*. The *sanitaristas* received the support of the democratising political elite because their action was considered central to undermine the Brazilian 'social debt' (Sader, 1999); they were influenced by the Declaration of Alma-Ata of the International Conference on Primary Health Care of 1978, where health was declared to be a fundamental human right; and were able to occupy the central space of the 8<sup>th</sup> National Health Conference of 1986 of Brazil, where health was declared 'to be the duty of the state and the right of the citizen' (Cornwall and Shankland, 2008). Previous national health conferences had not lead to the changes that the 1986 one did.

The transition would have its cornerstone in the writing of the new Constitution of 1988. Based on the work of the 1986 conference and with the *sanitaristas* playing a central role in its drafting (Rosário Costa, 2013), the Constitution recognised healthcare as a citizenship right secured by the state, guided by the principles of universalisation, equity and comprehensiveness; and mandated the creation of the *Sistema Unico de Saúde* (SUS). The SUS incorporated a 'participatory ethos' in the form of participatory health councils for the general population, and a national health conference for health care professionals, that aimed to integrate popular participation into the health care organisational model (Baiocchi, 2001, Baiocchi et al., 2008).

The SUS replaced the social insurance healthcare system of the INPS, legally extending coverage to the entire population under one unified system, with services offered as a right of citizenship free at the point of service. It would incorporate elements of the previous system like the participation of private providers, which resulted from the negotiation process for its creation, although under similar regulations than public providers securing, in principle, the notion of universal public service. In the early 1990s, the first president elected in direct elections was Fernando Collor de Melo, who headed a government of neoliberal orientation, as was the trend across Latin America in that period. Collor de Melo attempted but failed to dismantle the SUS, and after his impeachment on corruption charges, the development of healthcare under the SUS continued (Tolentino Silva, 2009).

### *The Mexican Case*

The first national social insurance legislation in Mexico was the *Ley del Seguro Social* (LSS), created in 1943, which mandated the creation of the Mexican Social Insurance Institute (IMSS), to provide benefits like healthcare and pensions to waged workers in formal employment paying contributions. (Brachet-Marquez, 2007). The IMSS was funded by payroll contributions from workers, employers and the state and was administered by a tripartite council of representatives from the three instances. The Secretariat for Labour was granted with the power to designate the labour and business organisations that would be represented (LSS, 1943). In 1960 an additional social insurance system was created to provide healthcare and other benefits to public sector workers, who in some cases had been receiving services and benefits since the 1920's under separate schemes (Carrillo Castro, 1987). For population

not covered by social insurance, like the self-employed, workers in informal employment and rural workers, and their families, only minimal and limited services which required the payment of user fees, were offered through the Secretariat for Health (SS) (Frenk et al., 1999, Lopez Acuña, 1980).

The development of healthcare under these fragmented structure continued for several decades, period in which Mexico had a hegemonic party regime. Under this regime, elections were celebrated systematically, without real electoral competition because the dominant party, the *Partido Revolucionario Institucional* (PRI), held an overwhelming control of political and economic resources and won virtually every election in the country (Crespo, 2003, Sartori, 1976).

Pressures for greater democratisation began to rise in the 1980s in the context of severe economic crises and the liberalisation of the economy. Contrary to the Brazilian case, no unified movement emerged in support of democracy. From the left, a faction that had split from the PRI in protest of neoliberal economic reforms, joined leftist parties and organisations to support the candidacy of Cuauhtémoc Cárdenas in the 1988 elections (Rodríguez Araujo, 2010). From the right, the conservative *Partido Acción Nacional* (PAN), which had represented the main opposition to the PRI since the 1930s, gained strength with the incorporation of business leaders (Loaeza, 1999). The most contested elections in the country's history until that year took place in 1988, when the PRI candidate Carlos Salinas defeated Cárdenas amidst strong accusations of fraud (Rodríguez Araujo, 2010).

The country would not transit towards a pluralist democratic system until a decade later. In fact, the PRI recovered fast from the 1988 elections and swept the 1991 mid-term elections, aided by a slight economic recovery and a number of clientelistic policies (Rodríguez Araujo, 2010). It was not until 1996, after new political and economic crises, that the definitive electoral reform was negotiated. This reform left in the hands of a citizen council the organisation and supervision of elections; the PRI lost the majority in the Chamber of Deputies in 1997, and the presidency in 2000 to the PAN's candidate Vicente Fox (Elizondo Mayer-Serra and Nacif, 2002).

The healthcare reform was introduced in 2002 by the Fox government. The team of reformers was led by the Health Secretary, Julio Frenk, former director of the private research institute Mexican Foundation for Health (FUNSALUD), funded by private corporations, among them pharmaceutical companies and private hospital consortiums (FUNSALUD, 2015). Most secretaries and high-ranking officials of the Secretariat for Health since 1982 have been associated with FUNSALUD, and the policy model followed based on regulated competition has been the one proposed by that institute, materialised during the Fox administration (Abrantes, 2010, Laurell, 2014). Although he had worked for the Secretariat for Health before, Frenk was working at the World Health Organisation (WHO) when he was recruited by Fox to join his presidential campaign (Abrantes, 2010, Laurell, 2007). Whilst working at the WHO, Frenk was criticised for favouring the evaluation of countries that had market-insurance based health systems, like Colombia, in detriment of countries with universal systems, like Cuba, which actually registered better indicators (Navarro, 2000).

The reform model was conceived by reformers years before (Frenk, 1994). Frenk had envisioned a system where public and private providers would compete for the allocation of services, where beneficiaries would have the option of choosing providers and where the government would act as purchaser (Frenk, 2005). Frenk's team first proposed to subsidise the affiliation of low income families to an IMSS voluntary health insurance scheme which had existed since 1997, with poor results due to the high premiums that were charged. That initiative would have resulted in a less fragmented system, but it failed as the IMSS workers' union opposed the creation of a market system of subcontracting that would have forced the IMSS to compete with other institutions (Lakin, 2010).

The decision was then taken to create a voluntary insurance programme along the existing social insurance ones. The new programme was called *Seguro Popular de Salud* (SPS). It offered health insurance to families with no social insurance coverage, albeit only for a limited package of 78 medical interventions. The number of interventions covered has increased since then, but unlike the social insurance system, full coverage has never been achieved and many illnesses remain excluded. The programme was funded by contributions from the insured families and the government. Family's contributions varied depending on the income decile where the family was placed after a means-test, with poor families belonging to the first two deciles being exempted (SS, 2005).

The design of SPS sought the objectives of creating a culture of prepayment among beneficiaries (SS, 2005); establishing a rational method for the allocation of resources by separating funding from service provider; and introducing a market system where a public purchaser, either the Secretariat for Health or a social insurance institute, would contract out public or private providers in a competitive environment and where patients' choice would be enhanced by allowing them to select the provider (Frenk et al., 2006).

The reform was debated in Congress, where the exemption of poor families from paying contributions was set as a concession to the leftist PRD, since the reformers original proposal considered only a partial subsidisation of contribution fees, not a total exemption. The programme was consolidated shortly by the rapid legal affiliation of beneficiaries, even if that implied misclassifying their income to place them within the exempted group, prompted by the PAN government's need for raising levels of support before the 2006 presidential elections, even if the infrastructure to provide services was absent or limited in many communities (Lakin, 2010).

## **Explaining the Choice of Reform Models**

From an institutional perspective, Hacker (2004) identified four modes of policy change that result from different sets of political conditions that reformers face. The Brazilian reform represents a case of formal revision that occurs when there are weak support coalitions of the existing policy, few veto players of the proposed change, and high levels of discretion by

reformers (Hacker, 2004, Pierson, 2004). In Brazil the previous social insurance system did not have strong support coalitions, since the government had removed official trade unions from the system's administration (Tolentino Silva, 2009). Trade unions could have represented an obstacle to the introduction of the SUS, like it happened in Argentina when a universal healthcare reform was proposed to replace social insurance shortly after the democratic transition too (Lo Vuolo, 1998). The reform did not face strong opposition in Congress as a broad coalition was formed to support it but the design of the SUS did incorporate important legacies from the social insurance system as a result of the negotiations with relevant actors, notably municipal governments and private sector providers (Cornwall and Shankland, 2008, Rosário Costa, 2013).

The Mexican reform represents a case of layering, that occurs when an existing policy has strong support coalitions, and reformers are forced to work around institutions with vested interests by adding a new policy along the existing one (Hacker, 2004, Pierson, 2004). Reformers took the decision to create an additional programme when they faced the opposition of the powerful IMSS workers' union, since their first proposal involved the internal conversion of that social insurance programme. Reformers also had to modify SPS's design as part of the negotiations with the Secretariat for Finance and left-wing parties in Congress (Dion, 2010, Lakin, 2010).

The analysis of the modes of policy change under this perspective can explain the policy outputs, namely the final design of the new healthcare programmes that came out of the reform processes; however, it does not explain policy inputs, namely the choices of the reform models that were originally selected in each country: a universal model with access based on social citizenship in Brazil, or an insurance model targeted at low income families in Mexico.

### *The effects of democracy*

Process tracing refers to the examination of intermediate steps of a political or social phenomena in a case or a small number of cases, to establish causal inferences about how that phenomena took place and how its outcomes were generated (Collier, 2011, Mahoney, 2015, Bennett and Checkel, 2015a). The approach is used for within case studies, but the comparative perspective is recommended to increase the power of inferential claims (Bennett and Checkel, 2015a). The first tasks of the approach are to identify the possible causes of the event that is trying to be explained, then to dismiss the ones that are considered to be dead ends and focus on the ones that are believed to hold a stronger explanatory potential (Mahoney, 2015, Bennett and Checkel, 2015a). In the present study, the event that is trying to be explained is the choice of healthcare reform models in each country.

Both reforms have in common that they were introduced immediately after each country's democratic transition. Democracy has been found to have a strong association with social policy expansion in Latin America, so it would constitute an optimal starting point. A review of the literature reveals that there are several mechanisms with which democracy has found to influence social policy expansion. One frequently noted effect is that electoral competition prompts governments to act in the social policy field, as politicians introduce and expand social



programmes to compete for the sympathy of the electorate (Kaufman and Nelson, 2004, Dion, 2010). Democracy has been found to make politicians more responsive to popular demands in order to gain electoral support (Kaufman and Nelson, 2004). On recent expansion processes, it has been argued that governments have expanded social policies to benefit informal sector workers and their families, historically excluded from social insurance, because they represent a new cross-class coalition of growing electoral power, negligible in previous decades of authoritarian rule but no longer under pluralist systems (Dion, 2010).

At the time when the reforms were introduced, both countries were experiencing levels of electoral competition unprecedented in their histories and the political parties in power were facing strong competition. Although in Brazil the PMDB had won the congressional elections of 1986 by a large margin, competition rose as new parties appeared and in the 1989 presidential elections, the PMDB candidate obtained less than five per cent of the voting (Nervo Codato, 2006). In Mexico, the PAN had won the presidential elections of 2000 with only slightly more than 40 per cent of the votes, did not win the majority in neither chamber of Congress and faced fierce competition from the PRI and the leftist *Partido de la Revolución Democrática* (PRD) (Crespo, 2003).

Electoral competition could explain why politicians took the decision to promote and approve the reforms, it might have motivated Brazilian congressional members to repel the counter-reform attempted by the Collor de Melo government, and had an effect on the fast consolidation of the SPS's affiliation in Mexico, as multiple declarations by Fox and his successor Felipe Calderón also from the PAN, hailing the programme as one of the main achievements of their administrations for campaign purposes could suggest (REF). However, the fact that this condition was present in both countries would not be sufficient to explain why different reform models were chosen.

Decentralisation processes associated to democracy have also been linked to social policy reforms in the region (Haggard and Kaufman, 2008). In the past, centralised structures were blamed for the lack of government responsiveness to local needs and demands, so since the 1980s a number of examples can be identified of attempts to transfer more resources and delegate responsibilities to regional and local governments. The Brazilian healthcare reform incorporated a decentralised logic and negotiations with municipal governments were crucial for its approval (Cornwall and Shankland, 2008). The Mexican reform also considered the decentralised provision of services, mounting SPS on the structure that had already been transferred by the federal government to state governments (Frenk et al., 2006, Lakin, 2010). However, following this explanatory path would not generate significant results, because even if decentralisation would have been the main objective pursued by reformers, it would not be sufficient to explain why they chose different reform models to achieve it.

The ideological orientation of political parties is another way in which democracy has been found to propel welfare policy reform, especially by enabling the formation and arrival to power of left-wing parties and coalitions. The link between leftist parties in government and universalist social policies has been observed for a long time in European countries, and is the basis of the power-resources theory of welfare state development (Korpi and Palme, 1998,

Esping-Andersen, 1985). The same argument has been made recently for Latin America (Pribble, 2014, Huber and Stephens, 2012). However, the Brazilian universal system was not introduced by a left-wing government. The PMDB is a centrist party, which at the time of the healthcare reform had actually built an alliance with the conservative *Partido da Frente Liberal* (PFL) (Mainwaring, 1999). The governments of parties that could be located on the left –the *Partido da Social Democracia Brasileira* (PSDB) and the *Partido dos Trabalhadores* (PT)– came years later. In the case of Mexico it could have been expected that the centre-right PAN would have favoured a targeted model like SPS, but in Brazil it was a centrist government with strong conservative influence which introduced the SUS. Political party orientation could explain the choice for the Mexican reform, but not of the Brazilian one.

Another way in which democracy has been linked to welfare reform in Latin America is by opening the political environment. It has been argued that political liberalisation provides the space for a wide debate on social issues and for the incorporation of new actors –like civil society organisations– into the policymaking process (Kaufman and Nelson, 2005). This is what happened in the case of the Brazilian reform with the incorporation of the *sanitaristas* into the government. In the case of Mexico, however, it would appear that democracy did not open up the political environment sufficiently enough to incorporate new actors into the social policy sphere. The Mexican democratic transition centred on the creation of a competitive electoral system (Nacif, 2003, Elizondo Mayer-Serra and Nacif, 2002).

Electoral competition and the attempts to decentralise services do not explain the choice of reform models. The ideological orientation of parties in power could explain the Mexican reform, but not of the Brazilian one. In the latter case, the role of civil society appears to have a strong explanatory potential of why a centre-right coalition in power introduced a reform of leftist orientation. The next section tests the hypothesis that the reasons for the universalist reform in Brazil lie in the incorporation of civil society actors into the decision structures of the state, and analyses it in a comparative perspective with the Mexican case.

### *The role of social mobilisation*

A second task in process tracing is to test whether a particular hypothesis caused the event that is trying to be explained (Mahoney, 2015), by analysing how causal processes took place and identifying their timing and sequencing (Waldner, 2015). The timing or conjunctures around an institutional or policy change refer to the interaction effects produced by certain events that occur at the same historical moment; sequencing refers to the order in which the events that influence the change occur (Pierson, 2004). For the cases under analysis, assuming that the role of civil society actors was crucial for the introduction of the Brazilian reform, the question would be how was it that in Brazil the democratic transition created the space for the incorporation of actors that proposed a structural social policy reform of universal features like the SUS; whilst in contrast, in Mexico no similar process unfolded.

The 1980s were times of both intense mobilisation for greater democratisation and contestation against neoliberalism throughout Latin America (Ferrero, 2014). The economic crisis that had hit Latin American countries in the 1980s, triggered a series of social protests.

Historic high levels of poverty and inequality which had at least to a certain level been ameliorated by the high economic growth rates of the previous four decades, exploded as a result of the debt crisis that hit Mexico first in 1982, and then by the structural adjustment programmes that were implemented at the recommendation of international financial institutions (Hipsher, 1998, Huber and Scott, 2004). Throughout the region, social protest capitalised from the generalised discontent and pressures for greater democratisation increased in every country (Hipsher, 1998).

Social mobilisation eventually became the main driver of the Brazilian healthcare reform. Social movements protests resulted first in the election of the opposition president in 1985, and then, crucial for the reform analysed here, in the decision in 1986 to call for elections of a constituent assembly that would be responsible for enacting a new constitution. Once the assembly was installed in early 1987, pressures from social movements managed to open up the debate on the drafting of the new constitution to public consultation (Versiani, 2010).

The *Movimento pela Reforma Sanitária* –where the *sanitaristas* emerged from–, was one among many civil society organisations that participated in the transition process demanding an answer to the question of the ‘social debt’. Given the strong pressures from civil society actors, the political class was prompted to open up the political environment to include them in the debate around institutional and policy changes (Ferrero, 2014). In the same year that the constituent assembly was being elected, the *sanitaristas* took over the national health conference, where they imposed their concept of public healthcare provision as a universal social right, which they would incorporate into the new constitution (Sader, 1999, Fleury, 2011, Versiani, 2010).

The new constitution would end up establishing as principal goals of the Brazilian Republic, the fight against poverty and social inequalities. The right to health reflected in the mandate for the creation of the SUS was assumed as a fundamental element to achieve those aims (Versiani, 2010). The reformers had an ideological commitment to the notion of health as a social right, which had been spearheaded by the social movement that where they had participated since the 1970s, and the conjuncture an open process of democratisation and large scale institutional changes, enabled them to incorporate it into the country’s institutional framework.

In Mexico, the timing and sequencing of events around the Mexican healthcare reform were very different. The 1980s in this country were also a period of intense social mobilisation. Many of these movements would coalesce around the presidential candidacy of Cárdenas in 1988. However, contrary to what happened in Brazil, the decade of the 1980s would not bring about the democratic transition. Cárdenas was defeated by Carlos Salinas amidst accusations of fraud, but after the elections, the PRI temporarily recovered its hegemonic position by boosting electoral support through measures like implementing clientelistic social programmes, making concessions to the centre-right *Partido Acción Nacional* (PAN), and temporarily stabilising the economy (Díaz-Cayeros et al., 2012); in the mid-term elections of 1991 it regained a large majority in congress and won the presidential elections again in 1994 by a large margin. The Salinas government would represent the consolidation of neoliberalism and of liberal

technocrats in the state's structure. Social mobilisation levels decreased and by 1995, many of the organisations that had supported Cárdenas in 1988 did not do so in that year. The Salinas government managed to put forward its ambitious programme of liberal reforms in alliance with the PAN (Rodríguez Araujo, 2010).

Social mobilisation surged again by the mid-1990s demanding fair and equitable elections. Social protests and the need to open up the political system after Zapatista rebellion and the political and economic crises of 1994-1995, became the main reasons why the government decided to negotiate the electoral reform that resulted in the transition (Aguayo, 2010). However, in contrast to Brazil, social mobilisation mostly focused on electoral issues, whilst the Zapatista movement centred on the rights of indigenous people and did not have an influence on other policy areas.

Demands for greater democratisation by social movements had a definitive effect on the transition process, but the political environment was not opened up enough to include social issues into the transition agenda. Beyond electoral reform, social mobilisation did not have an influence on the transition process. The incorporation of new actors into the decision-making structures of the state was limited, and the democratic transition represented more of a continuity with the liberal institutional and policy paths followed by previous administrations (Teichman, 2002, Rodríguez Araujo, 2010).

Proposals for reforming the state and implementing large-scale institutional changes – including a new constitution–, were halted (Carpizo, 2011, Aguayo, 2010), as the Fox government chose to privilege its alliance with conservative elements of the PRI and the business sector, with the aim of continuing the programme of liberal reforms (Teichman, 2002, Rodríguez Araujo, 2010). Since no deep institutional changes were undertaken, no political space was created for the incorporation of actors that could have brought demands for a more egalitarian model of social policy reforms.

Hence, the Mexican healthcare reform was proposed and designed by liberal policymakers identified with the same group that had been in charge of health policy in the country since the 1980s, associated to FUNSALUD (Abrantes, 2010). In fact, SPS follows the same targeted logic of a smaller programme called Essential Health Package, implemented in 1997 to provide a limited number of medical interventions for poor population with no social insurance (Laurell, 2001). The main difference is that SPS also applied an insurance logic, as reformers sought to promote a 'culture of pre-payment' and to create a market for the purchasing and provision of services between private and public actors (Frenk, 2005).

Figure 1 displays the sequencing of events that lead to the reforms, parting from the democratic transitions, understood as the periods of political liberalisation that immediately influenced the election of an opposition candidate in the presidency. The main cause that explains the differences is the role that social mobilisation played in each country's democratic transition. In Brazil, social mobilisation during the democratic transition, concerned with the fight against poverty and inequality and the establishment of social rights, was able to permeate the structures of the state to propose a universal reform. On the other hand, in

Mexico, the absence of social mobilisation in favour of social rights during the transition explains the continuity of liberal technocrats who proposed the market based targeted insurance reform model. The differences in the models that each group of reformers proposed was due to their ideational commitment to a certain notion of social policy, either as a universal social right in Brazil, or as a targeted mechanism conditional on contributions from recipients and with competition among providers in Mexico.

Figure 1 Sequencing of events for healthcare reforms

Brazil	Mexico
Democratic transition with social mobilisation for social rights ↓	Democratic transition with social mobilisation focused on electoral reform ↓
Open democratisation large scale institutional changes and popular participation ↓	Closed democratisation focused on electoral reform with narrow participation ↓
Incorporation of <i>sanitaristas</i> into the transition government ↓	Ratification of liberal technocrats in transition government ↓
Universal health reform model	Targeted market based insurance reform model

## Concluding Reflections

Both reforms have represented important efforts to expand public healthcare to groups of the population that for decades had been excluded from the action of the state. Yet, as has been explained, the model of reform matters because of the different consequences that each one can have for the population. The argument was made that the explanation for universalism in social policy can be found in the role that social mobilisation played during democratisation and policy reform processes. Whilst in Brazil the democratic transition enabled the incorporation into the structures of the state of grassroots actors concerned with an egalitarian model of public healthcare provision, in Mexico a narrower process of democratisation resulted in the continuity of policy actors that favoured a targeted model.

This article has demonstrated how social mobilisation can represent the difference when it comes to the adoption of universal social policy models that can have a greater positive impact on the welfare of the population. In the absence of pressures from grassroots movements, social policy may follow a similar fragmented path than that of the previous authoritarian regimes, as it happened in Mexico.

Social policies based on universal principles are believed to hold a greater potential at tackling poverty and inequality. There is evidence that this is true when comparing the Brazilian healthcare system with the Mexican fragmented system. Moreover, recent protests in Brazil have put demands to improve healthcare services at the centre of the public agenda, which would suggest that indeed universal social rights serve to aggregate political preferences. In Mexico, demands for better healthcare are scarce to say the least; in this country, a fragmented system could be blocking collective action. Further research is needed to investigate how policy promotes or blocks collective action, but it would seem that the 'paradox of redistribution' would be occurring in the cases analysed here.

This article also showed that rather than a unique process of democratisation and political liberalisation in the continent, the cases of Mexico and Brazil highlight the existence of different types of transitions. Zooming in at the healthcare reforms at times of political liberalisation and democratisation, from a comparative perspective, has revealed the mechanisms influencing the production of divergent policy reforms models.

The social mobilisation from below that forged the political transition managed from above in Brazil contributed to permeate the character of the transition and the conceptual orientation of the policy reforms enacted in the process. Although the transition in Brazil was possible due to elite pacts, it was the activation of unions and social movement organisation who established the narrative of the 'social debt'. In doing so, the discourse of social justice was mobilised from the margins to the mainstream, influencing institutional and sectorial reform. The transition in Mexico replicated the presence of the elite pact but it also showed the absence of a new contentious social narrative.

The evidence provided in the article is particularly relevant to (re)think the nature of state-society relations in contexts of democratisation. In Brazil, social movement organisations activated their members by raising new demands associated to the narrative of social justice. These demands were directed to the state which was perceived as a territory to be colonised rather than an apparatus to be toppled. As a consequence, the presence of the *sanitaristas*, who used the academic jargon to legitimise their narrative and gain broader societal consensus, was perceived as an achievement for the progressive forces and not as the result of state co-optation.

It was indeed the strategy of engagement with institutions followed by social movements in Brazil that produced lasting institutional legacies. The most apparent was the creation of a healthcare system of universal principles. And the more subtle but equally important was the opening of a fissure within the structures of the state which evidently contributed to prevent the total institutionalisation of neoliberalism as the hegemonic logic structuring the state.

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